U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

Issue Date: 02 August 2005

Case No.: 2003-BLA-0229

In the Matter of

CLINARD BENTLEY
Claimant

v.

KENTUCKY CARBON CORPORATION
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

APPEARANCES

Susie Davis, Lay Representative
For the Claimant

Natalie Gilmore, Esquire
For the Employer

Before: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER — DENYING BENEFITS ON MODIFICATION

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §§ 901 *et seq.* ("the Act"). Benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201(a) (2001).

This case was referred to the Office of Administrative Law Judges ("OALJ") for a formal hearing on June 27, 2003. (DX 125). On April 29, 2004, the hearing was held in Pikeville, Kentucky. Exhibits were admitted into evidence and the parties had full opportunity to submit additional evidence and to present closing arguments or post-hearing briefs. Both Employer and Claimant submitted closing arguments on June 28, 2004 and July 2, 2004, respectively.

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. They are based also upon my observation of the demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and considered. While the content of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title.[1] References to DX, CX, and EX refer to the exhibits of the Director, Claimant, and Employer, respectively. The transcript of the hearing is cited as "TR" and by page number.

ISSUES

The following issues remain for resolution:

1. whether Claimant has pneumoconiosis;

2. whether Claimant's pneumoconiosis arose out of coal mine employment;

3. whether Claimant has a total respiratory disability;

4. whether Claimant's total disability is due to pneumoconiosis;

5. whether Claimant has established a change in conditions and/or that a mistake was made in the previous determination of a fact in the prior denial pursuant to 20 C.F.R. § 725.310 (1999); and

6. whether Claimant has established a material change in conditions pursuant to 20 C.F.R. 725.309(d) (1999).

(DX 125; TR 13). At the hearing, the parties stipulated that Claimant had established 18 years of coal mine employment. (TR 13).

[1]Amended § 725.2 provides that amended §§ 725.309 and 725.310 (pertaining to duplicate claims and modification requests), do not apply to claims that were pending as of January 19, 2001. Section 725.2 provides that "a claim shall be considered pending on January 19, 2001 if it was not finally denied more than one year prior to that date." 20 C.F.R. 725.2 (2001). The instant duplicate claim was originally filed in 1994, and as of yet has not been finally denied as it is now and has been the subject of modification requests. Therefore amended §§ 725.309 and 725.310 are inapplicable to the instant claim. Similarly, the provisions regarding evidentiary limitations contained in 20 C.F.R. § 725.414 (2001) do not apply to the instant claim. 20 C.F.R. 725.2 (2001).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

Claimant, Clinard Bentley, married Willa Mae Bentley on November 3, 1956 and they remain married. (DX 8, 45; TR 17). Claimant was born on October 10, 1933 and he has a seventh grade education. (DX 1; TR 15).

Claimant filed his first claim for benefits under the Act on July 11, 1985. The District Director denied the claim on September 3, 1986 finding that although Claimant had a total respiratory disability, he did not have pneumoconiosis. After reconsidering the claim and additional medical evidence, the District Director again denied benefits in a letter dated April 5, 1988. Claimant requested a hearing, but his claim was ultimately deemed abandoned and was administratively closed on September 28, 1988. (DX 30).

Claimant filed his second claim for benefits on October 31, 1994. (DX 1). On April 10, 1995, the District Director denied benefits, finding that Claimant had not established that he had totally disabling pneumoconiosis. (DX 22). The District Director noted, however, that the "vents meet the standards for disability." (DX 22). After a hearing, Administrative Law Judge ("ALJ") Paul H. Teitler denied benefits in a Decision and Order issued on August 19, 1996 ("1996 D&O"), and found that Claimant had not established that he had pneumoconiosis arising from coal mine employment. (DX 44). Claimant subsequently requested modification of that denial. (DX 52, 53). The District Director denied the modification request and Claimant timely requested a formal hearing. (DX 75, 76). In a Decision and Order issued on June 29, 2001, the undersigned denied benefits. (DX 101). Claimant appealed that decision on July 6, 2001. (DX 102). The Benefits Review Board affirmed the denial of benefits and the denial of the modifycation request in an Order issued on March 20, 2002. (DX 107). Claimant requested reconsideration by letter dated April 12, 2002. (DX 108). The Benefits Review Board denied benefits upon reconsideration in an Order issued on June 5, 2002. (DX 110). In a letter dated June 19, 2002, Claimant requested that the claim be transferred to the District Director for modification. (DX 111). After reviewing additional medical evidence, the District Director denied the modification request in a Proposed Decision and Order issued on February 20, 2003. (DX 119). In this most recent denial, the District Director found that Claimant did not have pneumoconiosis arising from coal mine employment, nor did he have a total respiratory disability. (DX 119). The District Director also found that for purposes of the modification, no change in condition or mistake in the previous determination of a fact had been made. Claimant timely requested a formal hearing in a letter dated March 12, 2003. (DX 122). That hearing was held before me on April 29, 2004.

At the most recent hearing, Claimant testified that he began working in underground coal mine employment hand loading coal. (TR 16). He worked at Kentucky Carbon from 1967 until May 1985. He started out running roof bolters and loaders, and had also worked as a section foreman. (TR 17). Claimant testified that he has been treated by Dr. Sundaram for the last three years, and that he has been seeing Dr. Maynard for about 10 years. (TR 15). He stated that both physicians have prescribed breathing medications, including a nebulizer, inhalers, and oxygen.

(TR 16). With the exception of a chest x-ray report from Dr. Sundaram, neither physician has submitted a report or his treatment records in association with this modification request. Claimant testified that he smoked 1–1½ pack of cigarettes a day from 1965 until quitting in 1990. (TR 15). Claimant is currently receiving disability checks for a back injury he sustained while working at Kentucky Carbon. (TR 18).

Modification and Duplicate Claim Issues

Because Claimant filed his application for benefits after March 31, 1980, the regulations at 20 C.F.R. Part 718 (2001) apply. Under this part of the regulations, a claimant must establish by a preponderance of the evidence that he has pneumoconiosis; that his pneumoconiosis arose from coal mine employment; that he is totally disabled, and that his pneumoconiosis contributes to his disability. § 725.202(d)(1)(i)–(iv) (2001). Failure to establish any of these elements precludes entitlement to benefits. *See Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989). Claimant has the burden of establishing each element of entitlement by a preponderance of the evidence. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994).

The instant claim represents a duplicate (second) claim. As such, Claimant must fulfill the requirements of § 725.309(d), which applies to any claim for benefits that is filed more than one year after the denial of the previous claim. In the instant case, Claimant's initial claim was finally denied in September 28, 1988. He filed his second claim, the instant claim, on October 31, 1994. Therefore, in order to qualify for benefits Claimant must prove that the current evidence establishes a material change in conditions since the previous denial in 1988. 20 C.F.R. § 725.309(d) (1999). This section provides as follows:

> In the case of a claimant who files more than one claim for benefits under this part, the later claim shall be merged with the earlier claim for all purposes if the earlier claim is still pending. If the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the deputy commissioner determines that there has been a material change in conditions or the later claim is a request for modification and the requirements of 725.310 are met.

20 C.F.R. § 725.309(d) (1999).

In the case of *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir.), the United States Court of Appeals for the Sixth Circuit adopted the following standard for determining whether a miner has established a "material change in conditions:"[2]

> [T]o assess whether a material change in condition is established, the ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least

[2]Claimant's last coal mine employment took place in Kentucky. (DX 2). Therefore this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

> one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated as a matter of law, a material change. Then the ALJ must consider whether all of the record evidence, including that submitted with previous claims, supports a finding of entitlement to benefits.

Id. at 997–998. In *Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk]*, 264 F.3d 602 (6th Cir. 2001), the Sixth Circuit held that under *Sharondale*, an ALJ must compare the sum of the newly submitted evidence against the sum of the previously submitted evidence to determine whether the new evidence "is substantially more supportive of claimant."

As noted earlier, Claimant has previously established that he had a total respiratory disability.[3] The instant duplicate claim was most recently denied because Claimant was unable to establish that he has coal workers' pneumoconiosis. As will be discussed in detail below, the current evidence continues to support a finding that Claimant has a total respiratory disability. This total respiratory disability does not establish a material change in condition, however, because it is does not represent an element of entitlement that was previously adjudicated against Claimant. Therefore, Claimant must establish a material change in condition with new evidence by establishing the presence of pneumoconiosis.

In addition, the instant claim also involves a request for modification. Therefore, it must be denied unless newly submitted evidence demonstrates that one of the applicable conditions of entitlement has changed since the denial of his first request for modification of this duplicate claim in April 2002, or that the evidence of record demonstrates a mistake in the determination of a fact. 20 C.F.R. § 725.310(a) (1999). This section provides as follows:

> Upon his or her own initiative, or upon the request of any party on grounds of a change in conditions or because of a mistake in a determination of fact, the deputy commissioner may, at any time before one year from the date of the last payment of benefits, or at any time before one year after the denial of a claim, reconsider the terms of an award or denial of benefits.

20 C.F.R. § 725.310(a) (1999).

[3]In its most recent denial of February 20, 2003, the District Director specifically found that Claimant had not established that he had a total respiratory disability. (DX 119). However, in its original denial of Claimant's first claim on September 3, 1986, the District Director found that Claimant had a total respiratory disability, but denied benefits because he had not established presence of pneumoconiosis. (DX 30). In his 1996 D&O, ALJ Teitler acknowledged that "the finding has always been that the Claimant is totally disabled from a respiratory standpoint." (DX 44). I find that total respiratory disability is not an element of entitlement that has been previously adjudicated against Claimant.

In deciding whether Claimant has established a change in conditions, I must perform "an independent assessment of the newly submitted evidence, in conjunction with evidence previously submitted, to determine if the weight of the new evidence is sufficient to establish the element or elements which defeated entitlement …" *Napier v. Director, OWCP*, 17 B.L.R. 1-111, 1-113 (1993). *See also Nataloni v. Director, OWCP*, 17 B.L.R. 1-82, 1-84 (1993). In deciding whether the prior decision contains a mistake in a determination of fact, I must review all the evidence of record, including evidence submitted since the most recent denial. New evidence, however, is not a prerequisite to modification based upon a mistake of fact. *Nataloni*, 17 B.L.R. at 1-84; *Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156, 1-158 (1990), *aff'd on recon.* 16 B.L.R. 1-71, 1-73 (1992). *See also O'Keefe v. Aerojet-General Shipyards*, 404 U.S. 254, 257 (1971). In the case of reviewing for a mistake, the factfinder is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keefe*, 404 U.S. at 257.

Medical Evidence

The following is a summary of the newly developed medical evidence submitted with the instant request for modification.

A. X-ray Reports

Exhibit	**Date of X-ray**	**Date of Reading**	**Physician/ Qualifications**	**Interpretation**
DX 121	04/22/02	04/22/02	Sundaram	2/1, quality 1
DX 121	04/22/02	04/22/02	Potter	1/1, quality 1
EX 2	04/22/02	06/13/03	Wiot/BCR, B	Negative, quality 1
EX 1	04/22/02	06/19/03	Spitz/BCR, B	Negative, quality 1
EX 3	04/22/02	08/22/03	Shipley/BCR, B	Negative, quality 2 (dark)
DX 114	10/16/02	10/16/02	Baker/B	1/0, quality 1
DX 116	10/16/02	12/02/02	Wiot/BCR, B	Negative, quality 1
DX 117	10/16/02	12/11/02	Spitz/BCR, B	Negative, quality 1
DX 121	10/16/02	04/09/03	Patel/B	1/1, quality 2 (underexposed)
EX 3	10/16/02	08/22/03	Shipley/BCR, B	Negative, quality 1
DX 115	11/08/02	11/08/02	Dahhan/B	Negative, quality 1
DX 118	11/08/02	11/27/02	Wiot/BCR, B	Negative, quality 1
DX 117	11/08/02	12/11/02	Spitz/BCR, B	Negative, quality 1
DX 121	11/08/02	01/27/03	Patel/B	1/1, quality 2 (underexposed)
EX 3	11/08/02	08/22/03	Shipley/BCR, B	Negative, quality 1
EX 5	03/18/04	03/18/04	Hippensteel/B	Negative, quality 1

B. Pulmonary Function Studies

Exhibit	Date	Physician	Age/ Height	FEV_1	FVC	MVV	$\frac{FEV_1}{FVC}$	Tracings	Comments
DX 114	10/16/02	Baker	69/ 70″	.84	2.95	29	—	Yes	Severe obstructive defect
DX 115	11/08/02	Dahhan	69/ 70″	.96 1.04	2.08 2.22	25 29	46 47	Yes Yes	—
EX 5	03/18/04	Hippensteel	70/ 70″	.71 .97	2.09 2.74	19	34	Yes	Airflow obstruction; MVV is severely decreased; air trapping but no restriction; diffusion mildly decreased with normal ILCO/VA

C. Arterial Blood Gas Studies

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise	Comments
DX 114	10/16/02	Baker	40	76	Resting	Mild resting arterial hypoxemia
DX 115	11/08/02	Dahhan	42.4	76.9	Resting	Exercise terminated due to fatigue
EX 5	03/18/04	Hippensteel	44.5	69.4	Resting	Normal gas exchange at rest. Carboxyhemoglobin level is normal.

D. Narrative Medical Evidence

The record contains the opinions of Drs. Glen Baker, Randolph Forehand, Kirk Hippensteel, Thomas Jarboe, Abdul Dahhan, and Jerome Wiot. (DX 114; CX 1; EX 3, 5–10).

Dr. Glen Baker examined Claimant in association with his state workers' compensation claim on October 16, 2002. (DX 114). Dr. Baker is Board-certified in Internal Medicine and Pulmonary Disease.[4] He reported that Claimant worked at least 22 years in the coal mines ending in 1985. Dr. Baker listed Claimant's job duties as: handloading coal, operating a roof bolter, supervising, and running equipment. Dr. Baker assumed a smoking history of 1–1½ packs of cigarettes a day of 18 years duration. Claimant's subjective complaints included:

[4]American Board of Medical Specialties (visited July 27, 2005) http://www.abms.org.

productive cough, occasional wheezing, and shortness of breath. At this time, Claimant reported that these symptoms were aggravated by exertion; hot and humid weather; dust; odors; and fumes. Dr. Baker reviewed a pulmonary function study, an arterial blood gas study, and an x-ray. He interpreted the x-ray as positive for pneumoconiosis 1/0. Arterial blood gas studies showed "mild resting hypoxemia," and the pulmonary function study showed "chronic obstructive airways disease with a severe obstructive defect." In terms of disability Dr. Baker wrote:

> With the presence of pneumoconiosis, [Claimant] has a second impairment, based on Section 5.8, Page 106, Chapter Five, Guides to the Evaluation of Permanent Impairment, Fifth Edition, which states that persons who develop pneumoconiosis should limit further exposure to the offending agent. This would imply [Claimant] is 100% occupationally disabled for work in the coal mining industry or similar dusty occupations.

(DX 114). He wrote that Claimant had pneumoconiosis "based on abnormal x-ray and significant history of coal dust exposure." On a supplemental form, Dr. Baker also wrote that Claimant's pneumoconiosis arose out of his coal mine employment because "[h]e has no other condition to account for [his] x-ray changes." In response to whether Claimant's impairment was due to coal dust exposure, Dr. Baker wrote:

> Based on his 18 years of smoking and 22-28 year history of coal dust exposure and x-ray evidence of pneumoconiosis, it is felt that any pulmonary impairment would be caused at least in part by his coal dust exposure.

(DX 114).

Dr. Randolph Forehand reviewed Claimant's medical records. (CX 1). Dr. Forehand is Board-certified in Pediatrics, Board-certified in Allergy and Immunology, and is a B-reader. He is also Board-eligible in Pediatric Pulmonary Medicine. (CX 2). Dr. Forehand reviewed Claimant's medical records. In a letter dated March 18, 2004, he described that he assumed a coal mine employment history of 22 years and a smoking history of "up to 1½ packs of cigarettes daily from 1953 to 1990." Dr. Forehand noted that Claimant complained of shortness of breath, and used both nebulizers and oxygen on a daily basis. Dr. Forehand concluded as follows:

> These pulmonary evaluations consistently show that [Claimant] has a totally and permanently disabling respiratory impairment. Furthermore, [Claimant's] chest x-rays indicate that he has been exposed to high levels of coal mine dusts, which is understandable when taking into consideration his type of work in underground coal mining. On the other hand no chest X-ray revealed emphysema, the cause of obstructive lung disease from smoking cigarettes enlargement of the heart or congestive heart failure.

(CX 1). Dr. Forehand attributed Claimant's obstructive lung disease and "totally and permanently disabling respiratory impairment" to coal mine employment primarily and to cigarette smoking "secondarily." He also concluded: "[r]eturning to his last coal mining job would substantially aggravate [Claimant's] respiratory impairment and place him and his coworkers in jeopardy since he does not have the respiratory capacity to meet the physical demands of his last coal mining job." (CX 1).

Dr. Kirk E. Hippensteel examined Claimant on March 18, 2004. Dr. Hippensteel is Board-certified in Internal Medicine and Pulmonary Disease and is a B-reader. (EX 5). He also reviewed Claimant's medical records, and participated in a deposition on April 19, 2004. (EX 9). In a written report dated April 2, 2002, Dr. Hippensteel reviewed a chest x-ray, a pulmonary function study and an arterial blood gas study. He reported that Claimant's x-ray was "completely negative" for pneumoconiosis, and that his gas exchange was "in the normal range for his age." Pulmonary function studies showed "severe airflow obstruction with 36% improvement in FEV1 post bronchodilator indicative of marked reversibility." Dr. Hippensteel also reviewed Claimant's medical records and concluded:

> The extensive records reviewed in this case in addition to my own examination of this man and interpretation of additional x-ray evidence show with a reasonable degree of medical certainty that this man has severe, partially reversible obstructive respiratory impairment that is not typical for that caused by coal workers' pneumoconiosis. The evidence…overall…is against coal workers' pneumoconiosis or any coal mine dust induced disease of the lungs, with a reasonable degree of medical certainty. Most of his x-rays have been thought to be negative for pneumoconiosis, including those interpreted by myself, but even if it were stipulated that coal workers' pneumoconiosis were present radiographically, then his reversibility of function, chronic bronchial inflammation long after leaving work in the mines associated with variability in gas exchange without permanent impairment, as well as no permanent impairment in diffusion, are all in favor of bronchial disease secondary to asthma and his cigarette smoking, rather than disease that would expect to be fixed referable to his coal mine dust exposure. I agree with other experts who reviewed this case that this man is disabled enough from a pulmonary standpoint to be unable to go back to his job in the mines, with further impairment from nonpulmonary problems as well. The objective evidence in this case shows that this man would have been just as ill from these same problems had he never inhaled coal mine dust.

(EX 5).

Dr. Hippensteel was deposed on April 19, 2004. (EX 9). At this time, he reiterated his written findings and conclusions. He specifically testified that although chronic bronchitis can

be caused by coal mine dust exposure, it was his opinion that in this case it was not. Regarding bronchitis, he stated:

> It is a disease that, with coal dust exposure, is active during the time of active exposure to the irritant, coal dust, and in this case, he had stopped working in the mines in 1985, so such bronchitis from coal dust exposure would be expected to have long abated by now.

(EX 9, p.16). In reviewing a series of chest x-rays in this case, he found that they "were mostly negative for pneumoconiosis." (EX 9, p.18). In reviewing pulmonary function studies, he found an "asthmatic type response to bronchodilator therapy." (EX 9, p.19). Dr. Hippensteel also testified that pneumoconiosis "causes a fixed impairment, except for the industrial bronchitis that is active during coal dust exposure. It does not cause bronchial inflammation; it causes parenchymal lung disease, separate from what this man has." (EX 9, p.19–20). Dr. Hippensteel attributed Claimant's obstructive impairment to cigarette smoking. (EX 9, p.20). He also opined that Claimant did not have legal pneumoconiosis, and reported that although Claimant has a disabling respiratory impairment, it was "secondary to cigarette smoking, chronic bronchitis, and an asthmatic component." (EX 9, p.23). Dr. Hippensteel rebutted Dr. Forehand's conclusion that emphysema was the only type of obstructive lung disease that resulted from cigarette smoking, and testified that "chronic bronchitis is common to cigarette smoking, and it is a factor." (EX 9, p.24). He reiterated that pneumoconiosis is not a reversible type of impairment. (EX 9, p.25).

Dr. Thomas M. Jarboe reviewed the medical records in this case and participated in a deposition on April 8, 2004. (EX 7). Dr. Jarboe is Board-certified in Internal Medicine and Pulmonary Disease, and is also a B-reader. Dr. Jarboe had examined Claimant in the past in relation to his previous claim. (EX 7, p.5–6). He described that Claimant worked at least 22 years in coal mine employment running a loader and acting as a roof bolter and supervisor. (EX 7, p.13). Dr. Jarboe assumed a smoking history of 1–1½ pack of cigarettes a day from 1965 until 1990. (EX 7, p.14). He recorded Claimant's subjective complaints as including shortness of breath, daily cough, and wheezing. (EX 7, p.17). Dr. Jarboe testified that the entirety of chest x-ray evidence was "quite strong" that Claimant did not have pneumoconiosis. (EX 7, p.20–21). He described his physical findings, including hyperinflation of Claimant's lungs and stated:

> You can get emphysema and hyperinflation with coal dust inhalation. If you have very severe dust retention, you can get severe emphysema. But I think the one observation that helps us separate out causation of emphysema in these cases is that the degree of emphysema present in a particular case is proportionate to the amount of dust retention in the lungs. Said another way, if you see severe emphysema in a case, then you would expect to see very significant dust retention in the lungs, for example, on the chest x-ray.

(EX 7, p.22–23). Dr. Jarboe described that coal miners can get a "mild form of centrilobular emphysema, it's really called focal emphysema, around the dust macule, but this is usually very

mild and will cause only slight elevations of residual volume." (EX 7, p.24). He specifically testified:

> The pulmonary function evidence…is classical for a case of pulmonary emphysema which has been caused by longstanding cigarette smoking. I think that I just have talked about the degree of elevation of the residual volume, the amount of air trapping, in my opinion would not be seen in coal workers' pneumoconiosis unless there were severe dust deposition, and that's not the case here.

(EX 7, p.27–28). Dr. Jarboe also highlighted that Claimant "has repeatedly showed a significant reversible component to his airflow obstruction" and that this is not typical for pneumoconiosis, which causes a "fixed obstruction." (EX 7, p.28). Dr. Jarboe also opined that asthma is not caused by coal dust exposure. (EX 7, p.28). Dr. Jarboe wrote that the arterial blood gas evidence was "normal or only slightly reduced, not way out of range for a man of 70 years of age." (EX 7, p.30). Dr. Jarboe concluded that Claimant did not have coal workers' pneumoconiosis or "any other dust-induced lung disease that's been caused by, aggravated, or related to dust exposure." (EX 7, p.31). He reasoned that the x-ray evidence did not support such a diagnosis and further that:

> I think the physiology as we see it here is not all indicative of coal workers' disease. We've just said that [Claimant] has a significant reversible component to his airflow obstruction. That's not typical of coal workers' disease. It's quite typical of the bronchial reactivity that will result from smoking or from de novo asthma. We've also talked about the very high residual volume that [Claimant] has here. The degree of elevation of the residual volume, over 200 percent of normal, is very typical of a case of severe emphysema caused by smoking. Coal miners can get minor elevations but not nearly to this degree.

(EX 7, p.32). Additionally, Dr. Jarboe stated that the significant reductions in diffusion capacity together with the severe air flow obstruction, marked hyperinflation are "classical findings for cigarette-induced pulmonary emphysema." (EX 7, p.33). He attributed Claimant's pulmonary impairment to cigarette smoking-induced emphysema because of these findings. (EX 7, p.35). Dr. Jarboe opined that Claimant did not have a totally disabling pulmonary impairment. (EX 7, p.31).

Dr. Abdul Dahhan reviewed Claimant's medical records and participated in a deposition on April 12, 2004. (EX 6, 8). Dr. Dahhan is Board-certified in Internal Medicine and Pulmonary Disease/B-reader. (EX 6). In his written report from dated March 30, 2004, Dr. Dahhan described that he had examined Claimant in the past and had previously concluded that Claimant had chronic obstructive lung disease that was totally disabling from "a respiratory standpoint." (EX 6). He noted that Claimant had established a coal mine employment history of 24 years and a smoking history of approximately 38 years of smoking 1–1½ packs of cigarettes

a day. (EX 6). He reviewed a series of medical reports and chest x-rays, pulmonary function studies, and arterial blood gas studies. Dr. Dahhan presently concluded:

> I continue to find insufficient objective findings to justify the diagnosis of coal workers' pneumoconiosis based on the obstructive abnormalities on clinical examination of the chest, variable obstructive abnormality on pulmonary function testing with response to bronchodilator therapy and negative x-ray reading for pneumoconiosis.

(EX 6). He concluded that Claimant had chronic obstructive lung disease and that he had a total respiratory disability. He noted, however, that it "has resulted from his lengthy smoking habit with no evidence of pulmonary impairment and/or disability caused by, related to, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis." (EX 6).

Dr. Dahhan had examined Claimant on November 8, 2002. In a letter dated November 12, 2002, he described his findings. (DX 115). He wrote that Claimant worked underground as a coal miner for 24 years, ending in 1985. Dr. Dahhan assumed a 38–57 pack-year history of cigarette smoking. At this time, Claimant's subjective complaints included productive cough, occasional wheeze, and shortness of breath. Dr. Dahhan reviewed the results of chest x-ray, pulmonary function studies, arterial blood gas tests, and electrocardiograms. He also reviewed Claimant's medical records and other physician reports. The chest x-ray showed emphysema, but no pneumoconiosis. Pulmonary function studies showed a "severe partially reversible obstructive ventilatory defect with no evidence of a restrictive ventilatory abnormality." Dr. Dahhan concluded that Claimant had chronic bronchitis and emphysema, and that he had a total respiratory disability. Dr. Dahhan also concluded that Claimant did not have pneumoconiosis or any coal dust-induced lung disease, and that Claimant's total respiratory disability was not due to, nor aggravated by inhalation of coal mine dust. Dr. Dahhan opined as follows:

> [Claimant's] obstructive ventilatory defect has resulted from his length smoking habit that has been reported by me and other physicians, which is sufficient to be injurious to the respiratory system and cause the development of a disabling ventilatory impairment.

(DX 115). He also wrote that Claimant's defect:

> demonstrates variable response to bronchodilator therapy, a finding that is inconsistent with the permanent adverse affects of coal dust on the respiratory system. His physician is treating with three different bronchodilators indicating that he believes the patient's condition is responsive to such measures, another finding that is inconsistent with the permanent fixed adverse effects of coal dust on the respiratory system.

(DX 115). Dr. Dahhan concluded that Claimant had hypertension, non-insulin dependent diabetes mellitus, and post left endarterectomy, but no conditions related to his coal mine employment. (DX 115).

In his deposition testimony, Dr. Dahhan reiterated many of the findings contained in his written reports. He emphasized that the "bulk" of the chest x-ray evidence was negative for pneumoconiosis. (EX 8, p.18). Dr. Dahhan also noted that while focal emphysema can be seen in individuals with coal workers' pneumoconiosis, he stated "I cannot rule it out" when asked if it was present in this case. (EX 8, p.20). He described that the pulmonary function tests showed airway obstruction "of various severity." (EX 8, p.21). When asked why he attributed the obstructive defect to cigarette smoking and not coal workers' pneumoconiosis, he testified:

> One, the variable reversibility following the administration of bronchodilators which indicates that the airway obstruction is not fixed. That finding contradicts the possibility that it is due to the inhalation of coal dust that causes a fixed obstructive impairment when it does so. The fact that the individual is being treated with various bronchodilator therapy supports the notion that his treating physician does indeed believe it is amenable to bronchodilator and is not fixed in nature. Additionally, the severity of the airway obstruction which is causing complete pulmonary disability which is not seen secondary to inhalation of coal dust, per se, since the inhalation of coal dust, if it causes airway obstruction, results in the loss of only 5 cc. per year of exposure to coal dust.

(EX 8, p.23). Dr. Dahhan also testified that Claimant did not have legal pneumoconiosis or any other coal mine dust-induced lung condition, but that he was totally disabled from a respiratory standpoint. (EX 8, p.25–26).

Dr. Jerome F. Wiot participated in a deposition on April 21, 2004. (EX 10). Dr. Wiot is a Board-certified radiologist and was one of the physicians originally designated as a "C-reader" of x-rays. (EX 10, p.4–10). Dr. Wiot testified regarding the importance of reviewing a series of chest x-rays of patients in order to diagnose and see changes in their lungs over the course of time and opined that:

> coal workers' pneumoconiosis is manifested radiographically by the presence of small, rounded and sometimes irregular opacities, which tend to begin in the upper lung fields. The more often, interestingly enough, they early occur in the right upper lung field rather than the left.

(EX 10, p.16–18). He described how pneumoconiosis tends to go "down the chest rather than up." (EX 10, p.18–19). Dr. Wiot read 11 x-ray films of Claimant's lungs and found emphysema on many of the films because the "lungs look over-expanded, the diaphragm is flattened a little bit and that's suggestive to us of emphysema." (EX 10, p.26). Dr. Wiot testified that for a "patient to have a normal chest x-ray at the time that he leaves the coal mine and then to develop

[pneumoconiosis] five years later is very, very, very unusual." (EX 10, p.32). After reviewing the films, Dr. Wiot testified that Claimant "has absolutely no evidence of coal workers' pneumoconiosis on any of the chest x-rays." (EX 10, p.33).

DISCUSSION OF EVIDENCE AND APPLICABLE LAW

Pneumoconiosis and Causation

Section 718.202 provides four means by which pneumoconiosis may be established: by chest x-ray; a biopsy or autopsy; by presumption under §§ 718.304, 718.305 or 718.306; or if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201.[5] 20 C.F.R. § 718.202(a)(1)–(4). The regulatory provisions at 20 C.F.R. § 718.201 contain a definition of pneumoconiosis provided as follows:

> (a) For the purposes of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical," pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> > (1) Clinical pneumoconiosis. "Clinical Pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
> >
> > (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

§ 718.201(a)(1)–(2).

[5]Only the x-ray evidence and the physicians' opinions are applicable under these facts. Section 718.202(a)(2) is inapplicable because there are no biopsy or autopsy results. Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of the several presumptions is found to be applicable. In the instant case, § 718.304 does not apply because is no x-ray, biopsy, autopsy or other evidence of large opacities or massive lesions in the lungs. Section 718.305 is inapplicable to claims filed after January 1, 1982. Section 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982.

It is within the administrative law judge's discretion to determine whether a physician's conclusions regarding pneumoconiosis are adequately supported by documentation. *Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46, 1-47 (1985). "An Administrative Law Judge may properly consider objective data offered as documentation and credit those opinions that are adequately supported by such data over those that are not." *King v. Consolidation Coal Co.*, 8 B.L.R. 1-262, 1-265 (1985).

X-ray Evidence

Pursuant to § 718.202(a)(1), the existence of pneumoconiosis can be established by chest x-rays conducted and classified in accordance with § 718.102. It is well-established that the interpretation of a chest x-ray by a B-reader may be given additional weight by the fact-finder. *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32, 34 (1985); *Martin v. Director, OWCP*, 6 B.L.R. 1-535, 537 (1983); *Sharpless v. Califano*, 585 F.2d 64, 666–67 (4th Cir. 1978). The Board has also held that the interpretation of a chest x-ray by a physician who is a B-reader as well as a Board-certified radiologist may be given more weight than that of a physician who is only a B-reader. *Zeigler Coal Co. v. Kelley*, 112 F.3d 839, 842–43 (7th Cir. 1997); *see also Bethenergy Mines, Inc. v. Cunningham,* Case No. 03-1561 (4th Cir. July 20, 2004) (unpub.).

The newly submitted x-rays do not support a finding of pneumoconiosis. The chest x-ray film taken on April 22, 2002 was interpreted as negative by three dually-qualified radiologists and as positive by only two physicians, neither of whom are B-readers or even radiologists.[6] I find that this x-ray is negative for pneumoconiosis.

The October 16, 2002 x-ray film was also interpreted as negative for pneumoconiosis by three dually-qualified radiologists and as positive by two physicians who are only B-readers. I find that this x-ray is negative for pneumoconiosis.

The November 8, 2002 chest x-ray film was interpreted as negative by four dually-qualified radiologists and as positive by only one physician who is only a B-reader. I find that this x-ray is negative for pneumoconiosis.

Finally, the most recent chest x-ray taken on March 18, 2004 was read as negative by a B-reader. There are no positive readings of this film. I find that this x-ray is negative for pneumoconiosis.

In this case, the overwhelming majority of x-rays interpreted by dually-qualified radiologists were read as negative. Based on the foregoing, pneumoconiosis has not been established under § 718.202(a)(1).

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[6]Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Also, information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org. In this case, reference to both of these websites indicates that neither Dr. Sundaram nor Dr. Potter is a B-reader, nor is either a radiologist.

Medical Opinions

Section 718.202(a)(4) provides the fourth and final way for a claimant to prove that he has pneumoconiosis. Under § 718.202(a)(4), a claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that a miner suffers from pneumoconiosis. Although the x-ray evidence is negative for pneumoconiosis, a physician's reasoned opinion might support the presence of the disease if it is supported by adequate rationale besides a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 1-22, 1-24 (1986). The weight given to a medical opinion will be in proportion to its documented and well-reasoned conclusions.

A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Fuller v. Gibraltar Coal Corp*., 6 B.L.R. 1-1291 (1984). A report may be adequately documented if it is based on items such as a physical examination, symptoms and patient's history. *See Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Buffalo v. Director, OWCP*, 6 B.L.R. 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp.*, 2 B.L.R. 1-130 (1979).

A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). The determination that a medical opinion is "reasoned" and "documented" is for the ALJ to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (*en banc*).

Dr. Baker diagnosed pneumoconiosis on the basis of his positive interpretation of the October 16, 2002 chest x-ray and history of coal mine employment. Dr. Forehand diagnosed an "obstructive lung disease" arising from coal mine employment, a diagnosis that is equivalent to a finding of legal pneumoconiosis. These opinions are documented and reasoned. I find that the weight of Dr. Baker's opinion is diminished, however, by his reliance on a positive x-ray that has ultimately been deemed negative for pneumoconiosis.

The other physicians of record, Drs. Hippensteel, Dahhan, and Jarboe found no evidence of either clinical or legal pneumoconiosis. Their respective opinions are documented and reasoned, and these three physicians are all board-certified pulmonologists. Although Dr. Baker is also a board-certified pulmonologist, I have found that his opinion is entitled to lesser weight because of his reliance on a negative x-ray. In considering all of these opinions, I find that the positive physician opinion evidence does not constitute a preponderance of evidence as the majority of better qualified physicians did not diagnose pneumoconiosis. Therefore, Claimant is unable to carry her burden of establishing pneumoconiosis under § 718.202(a)(4).

In summary, as neither the x-ray evidence nor the physician opinion evidence is sufficient to establish the presence of pneumoconiosis, the newly submitted evidence as a whole is necessarily insufficient to establish the presence of pneumoconiosis. Therefore, Claimant has not shown a change in conditions, nor has he shown a material change in condition as required by §§ 725.310(a) and 725.309(d).

Evidence of Total Disability Due to Pneumoconiosis

A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b)(1). Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis. 20 C.F.R. § 718.204(a). The regulations at 20 C.F.R. § 718.204(b) provide the following five methods to establish total disability: (1) pulmonary function (ventilatory) studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinions; and, in some cases, (5) lay testimony. 20 C.F.R. § 718.204(b)(2)(i)-(iv), (d). Non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability. *See Beatty v. Danri Corp.*, 16 B.L.R. 1-11, 1-15 (1991). Section 718.204(b)(2) provides several criteria for establishing total disability. Under this section, I must first evaluate the evidence under each subsection and then weigh all of the probative evidence together, both like and unlike evidence, to determine whether claimant has established total respiratory disability by a preponderance of the evidence. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1987).

Under §§ 718.204(b)(2)(i) and (b)(2)(ii), total disability may be established with quailfying pulmonary function tests or arterial blood gas studies. All ventilatory studies of record, both pre-bronchodilator and post-bronchodilator, must be weighed. *Strako v. Ziegler Coal Co.*, 3 B.L.R. 1-136 (1981). To be qualifying, the FEV1 as well as the MVV or FVC values must equal or fall below the applicable table values. *Tischler v. Director, OWCP*, 6 B.L.R. 1-1086 (1984). For arterial blood gas studies to be qualifying, they must correspond to the values listed in Appendix C. § 718.204(2)(ii).

In the instant case, the newly submitted arterial blood gas studies did not produce quailfying results. However, both the newly submitted pulmonary function studies and the majority of newly submitted physician opinion evidence of record overwhelming support a finding of total respiratory disability. The pulmonary function studies produced qualifying results and, with the exception of Dr. Jarboe, both Claimant's and Employer's experts agree that Claimant has a total respiratory disability. Therefore, I find that the newly submitted evidence supports a finding of total respiratory disability. As noted above, however, total respiratory disability is not an element that was previously denied, thus its establishment does not represent either a material change in condition or a change in condition for purposes of either §§ 725.309(d) or 725.310(a).

ENTITLEMENT

I find that upon review of the newly submitted evidence, it is not "substantially more supportive" of claimant's position under *Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk]*, 264 F.3d 602 (6th Cir. 2001). In fact, the newly submitted evidence as a whole is quite similar to that which has been previously submitted. The x-rays have been consistently negative as a whole. The physician opinion evidence has also generally strongly favored a negative finding of pneumoconiosis, as the negative opinions have been either better reasoned, or entitled to more weight because of the physician's respective qualifications.

Finally, in further reflecting on the record for purposes of § 725.310 analysis, I find that no mistake was made in the previous determination of a fact. Notably, Claimant has alleged none.

After a review of the newly submitted evidence, I find it continues to support a finding that Claimant has a total respiratory disability. However, on review of the newly submitted evidence, Claimant has not established that he has pneumoconiosis, nor shown a material change in condition for purposes of § 725.309(d). In addition, I find that he has not established a change in condition nor shown that a mistake was made in the prior determination of a fact for purposes of modification under § 725.310(a).

Conclusion

In sum, I find that Claimant is unable to establish that he has pneumoconiosis arising from coal mine employment, and is therefore unable to prove that his total respiratory disability is due to coal workers' pneumoconiosis. Accordingly, Claimant is not entitled to benefits under the Act.

Representative's Fee

The award of a representative's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

The claim of CLINARD BENTLEY for benefits under the Act is hereby DENIED.

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JOSEPH E. KANE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601,

Washington, D.C. 20013-7601. A copy of this notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.